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Research paper

The delivery and management of telephone befriending services – whose needs are being met?

Introduction

Loneliness among older people has received increasing policy attention (World Health Organization, 2004; AGE Platform EU and Committee of the Regions, 2009; Department of Health, 2010a; Lang *et al.*, 2010). There are several reasons for this. Firstly, the growing number of older people raises issues about the design and the prioritisation of services (Lloyd-Sherlock, 2002; Department of Health, 2006; Strumpel and Billings, 2008; European Commission and Economic Policy Committee, 2009; Department of Health, 2010b) and secondly there is growing research evidence showing a strong association between quality of life, mental ill health, physical health and loneliness (Penninx *et al.*, 1997; Alpass and Neville 2003; Routasalo *et al.*, 2006; Bowling and Gabriel 2007; Masi *et al.*, 2010). Finally, data suggests that despite efforts, the prevalence of loneliness in later life has remained about the same for the past 40 – 50 years (Victor *et al.*, 2009), which means an actual increase in absolute numbers of older people who experience loneliness. In Europe, depending on the survey, the prevalence of older people (aged 60+) who are sometimes or often lonely is between 30 and 40 percent (Dykstra *et al.*, 2005; Victor *et al.*, 2005; Routasalo *et al.*, 2006). In addition, some research suggests that loneliness increases with age, although this seems to be dependent on partner and functional health status (Dykstra *et al.*, 2005; Heikkinen and Kauppinen, 2011).

Loneliness has been described as an undesirable, subjective and negative feeling of lack or loss of meaningful relationships. In other words, it is the individual's judgement about the desirability of the quality and quantity of their existing relationships, which determines their experience (de Jong Gierveld *et al.*, 2006; Scharf and de Jong Gierveld *et al.*, 2008).

One of the risk factors for loneliness is living alone, although research suggests that this is possibly linked to the amount of time spent alone and the size of the individual's social networks (de Jong Gierveld *et al.*, 2006). It may be that a person living alone is at greater risk of loneliness because they are reliant on their personal assets to access external social connections and services. Studies in the UK and Australia have found that loneliness is frequently reported by people living in rented accommodation and in single dwellings, particularly if they have been forced into the situation as a result of widowhood or divorce (Bennett and Dixon, 2006; Franklin and Tranter, 2011). In a European cross-cultural survey (SHARE), older women living alone were more likely to report poor mental health and decreased subjective health (Rueda *et al.*, 2008; Gaymu & Springer, 2010), although the reasons for this varied between countries (Gaymu and Springer, 2010).

Until recently, the number of older people living alone has been rising. However, projections for Europe suggest that by 2030 fewer older women aged 75 and over will actually live alone because of declining widowhood, while for men aged 75-84 this figure will rise slightly as a result of greater divorce rates (Gaymu *et al.*, 2008). Consequently, older people in poor health may also be more likely to live in a couple. This could mean that older people in poor health are less likely to become

institutionalised in the future, but on the other hand, it might lead to people living in a couple, becoming more isolated and lonely as a result of caring for someone in poor health. Mellor *et al.*, (2008) found that dissatisfaction with one's personal relationships is associated with greater feelings of loneliness, regardless of living circumstances. In other words, a person living with someone can still feel lonely if the quality of the relationship does not meet his/her expectations. Loneliness is, therefore, the perceived gap between the expected and the actual social relationships (Yang and Victor, 2011).

Understanding the characteristics of loneliness matters when it comes to developing programmes to alleviate loneliness that are acceptable to older people and volunteers and realistic for services to implement. Previous research has found that organisational and structural changes may be required in order for organisations to create environments that are responsive to the needs of their older clients and their volunteers (Narushima, 2005; Gillespie *et al.*, 2011). This does not always happen. Despite recognising the value of user engagement in programme development, organisations are often content or forced to develop services that are structured around their own or their funders' requirements (Narushima, 2005; Reeve and Peerbhoy, 2007; Rummery, 2009; Warwick, 2011). Frequently the cumbersome structures and bureaucracy in organisations act as barriers to older people having a voice in service development (South *et al.*, 2010).

This study evaluated a national pilot programme 'The Call in Time Programme', which consisted of eight telephone support projects in different locations across England and Scotland, managed by voluntary or charitable organisations, each with its own operational structure. The programme was initially funded by Help the Aged (which merged with Age Concern in 2009 to form Age UK) in partnership with the insurance company Zurich. The rationale was based on the notion that compared with face to face befriending, telephone befriending provides a low level, low cost and low risk intervention, with volunteers offering emotional support for housebound older people from their workplace or from their own home. Several of the projects from the original programme continue to receive funding from Age UK and other organisations. In this paper, we consider the organisational issues that emerged through the study. In particular, we focus on those individuals who manage the telephone support projects, the co-ordinators, and the key factors they face in delivering the service for older people. The evaluation of the programme, from the perspective of the older people receiving the service is published elsewhere (Cattan *et al.*, 2009; Cattan *et al.*, 2011).

Methods

A mixed-methods approach was used involving recipients of the telephone support projects and project co-ordinators who managed the individual services. Recipients participated in telephone questionnaires, health diaries and focus group discussions. Project co-ordinators participated in semi-structured interviews and a Delphi survey. Here we report on the findings from the semi-structured interviews and the Delphi survey involving the project co-ordinators, which enabled an exploration of the eight telephone support projects and the way each service was organised.

Semi-structured interviews

All eight project co-ordinators agreed to participate in a single semi-structured interview lasting approximately one hour. The aim of the interviews was to explore in more detail the different service models, for example, procedures relating to the day-to-day workings of the service, recruitment, referrals, promotion and publicity, structure and management and support mechanisms associated with the service. In addition, project co-ordinators' perceptions of the strengths, challenges and necessary service improvements were addressed. It was felt that one-to-one, semi-structured interviews provided the mechanism by which the project co-ordinators could openly discuss their respective projects. Furthermore, this approach gave the researcher flexibility to raise new questions within the broad interview framework, according to what individual co-ordinators said about their project. In each case the interviews took place at the project co-ordinators' place of work.

Delphi survey

Five of the eight project co-ordinators participated in the Delphi survey, which followed on from the semi-structured interviews. The aim of the Delphi survey was to explore in greater depth the different service models and identify the most relevant issues for project co-ordinators managing the telephone support services.

A Delphi style survey is a structured group interaction process that is directed in 'rounds' of opinion collection and feedback. The technique is designed to achieve group consensus using anonymity, iteration, controlled feedback and statistical group response (Jones and Hunter, 1995), by allowing participants to compare their responses with those of colleagues, and is often used in the development of guidelines (NICE, 2009; Wagenaar *et al.*, 2003). Opinions are collected by conducting a series of surveys using questionnaires. Participants are asked to rate each issue using a Likert scale and a group mean score is generated for each ranked statement. The results of each survey are presented to the group and the questionnaire used in successive rounds of the survey is compiled based on the results of the previous round to reach a final consensus view of priorities within the issue being explored.

In this study, themes from the analysis of the semi-structured interviews formed the basis of the questionnaire and included questions relating to promotion and publicity of the telephone support service, structure of the telephone support service, characteristics of an effective telephone support service, referrals and recruitment of volunteers. Project co-ordinators' opinions and feedback were collected through a series of three postal questionnaires. In the first round, a series of statements were provided under each heading (Cattan *et al.*, 2011) and participants were asked to rank their agreement with each statement, using a five point Likert scale with responses ranging from 'strongly agree' to 'strongly disagree'. The researcher then summarised the rankings for each statement. Only those statements where consensus was not reached in the first round were included in the second round. Summary scores from the first round were presented as means for each included statement to give participants the opportunity to adjust their score towards the average if they wished. The process was then repeated. In this way a consensus was reached regarding the most relevant issues for telephone support services.

A written and verbal explanation to the study was given, informed consent obtained and confidentiality assured. The semi-structured interviews were recorded with the participants' consent and appropriate ethical approval was obtained.

Analysis

The semi-structured interviews were transcribed verbatim. The analysis of the data commenced during the data collection phase of the research, in order that initial themes could be identified and specific areas warranting additional investigation explored in further interviews. Analysis and interpretation followed 'Framework Analysis', a case by theme approach, which is a practical and effective way of managing, summarising and synthesising complex qualitative data (Ritchie and Lewis 2003). It is data driven and does not presume orientations or themes. The analysis of the Delphi survey is described above as part of the survey process. Findings from the semi-structured interviews and the Delphi survey are presented here concurrent with a mixed-method approach.

Findings

Four key areas emerged as priority issues. These were:

- Operational Structure;
- Promotion and publicity;
- Recruitment of volunteers;
- Referral processes.

Operational Structure

In its entirety, the telephone support programme aimed to support between 800 – 1000 older people. The individual projects varied in terms of length of operation and the number of older people and volunteers participating in the projects. In all cases, a project co-ordinator managed the individual projects. Characteristically, the service participants were often housebound, had restricted mobility, lived alone and were reliant on external agencies for their health and social care needs. Calls to the older people were made by volunteers and the project co-ordinators. The number of volunteers in the individual telephone support projects ranged from 1 – 30. This, and the resources available, influenced the number of calls made, usually organised through a weekly rota.

The majority of projects existed to provide companionship and were, therefore, based on scheduled weekly telephone calls between clients and volunteers. Other projects were established as either an emergency response service or as a support service for older people at key times of need, for example, on returning home from hospital. In these cases the organisation of the telephone support, although formalised, was less frequent and more focused on responding to a single incident. Some projects had evolved to take on additional roles, such as face-to-face visits and/or telephone clubs reflecting members shared interests.

The consensus amongst project co-ordinators was that individual projects did not need to be identical and each should have the flexibility to develop and adapt as and when appropriate, according to the changing needs of their clients. Although the support was provided over the telephone initially, project co-ordinators agreed there should be the additional option of face-to-face support, although in practice this was

not always feasible because of limited resources. The general consensus was for a telephone support service to be based on a combination of telephone calls and peer-to-peer support, where all members could be encouraged to make telephone calls as well as receive them, thereby developing 'telephone clubs'.

The telephone support projects were managed either by a full-time or part-time project co-ordinator. In the case of those who were part-time, important issues were time and resources available to manage the service effectively. Many co-ordinators worked more than their contractual hours and did so because the continual operation of the project depended on it,

"From start to finish, you go out, you promote the project, you get the volunteers, you do all of the application forms, getting them on the database, introduce them...problem solving...you try to do a thousand jobs in the hours; invariably you go over the hours."

Project co-ordinators recognised that an important factor in the management of the projects was finance, although the decisions relating to finance did not fall within the remit of the project co-ordinators' role. However, aside from the larger issue of funding allocation, which project co-ordinators felt they had little control over, project co-ordinators did acknowledge that individual projects would be better managed if they were responsible for the finances and therefore, able to make decisions on where to focus funding within the project. It was important for project co-ordinators to have a good working relationship with their manager, with support provided through regular visits and telephone calls. Project co-ordinators highlighted the issue of training and felt that they needed more training in certain areas, for example, dementia. In addition, they reported that they had little time for monitoring and record keeping, but understood the benefits of doing so, in particular to demonstrate to funders a continued need for the service. Although project co-ordinators completed their paperwork when they could, they did not refer to any training that they had received in this area, for example, project management or similar.

Promotion and publicity

A large part of the project co-ordinators' role involved promoting and publicising the telephone support service. Many projects had no formalised procedure in place for promotion and publicity and this tended to happen on an ad hoc basis. Since many project co-ordinators worked part-time, the amount of time available for promotion and publicity on top of other service related tasks was minimal. Project co-ordinators felt the profile of the telephone support projects needed to be raised to increase awareness of their existence, value and health benefits, in particular amongst older people, their carers and voluntary agencies. The consensus was that this was best achieved through consistent messages applied across the service as a whole. However, given the wide variation in geographical location of the individual projects, it was felt that the funding organisation, in this case Help the Aged (now Age UK), needed to take responsibility for the generic promotion and publicity of the telephone support service. Project co-ordinators agreed they should be responsible for local promotion and publicity as they were aware of local needs and networks within their area. One suggestion was to use standardised host organisation templates personalised by project co-ordinators, as a way of ensuring material was appropriate for individual projects.

Recruitment of volunteers

Project co-ordinators were responsible for the recruitment and training of volunteers. To ensure the projects were sustainable it was important for project co-ordinators to invest time in recruiting volunteers and to make available structured training programmes. However, this took up a large amount of time. Project co-ordinators tended to recruit volunteers through organisations they already worked with. This was their preferred method since established volunteers already had the required clearance from the Criminal Records Bureau, which meant the recruitment process was often quicker. The general consensus was that the responsibility for recruitment of volunteers should be that of the project co-ordinator or a delivery partner such as WRVS (Women's Royal Voluntary Service). Project co-ordinators thought it was important to match volunteers to clients according to shared interests rather than any other criteria, such as ethnicity, gender or age. All that was needed for an individual to volunteer was a telephone.

The relationship between the project co-ordinator and volunteer was highlighted as a key issue. Project co-ordinators felt it was their responsibility to ensure volunteers were happy and well looked after. They were aware that volunteers were not paid members of staff and could leave at any time. This meant project co-ordinators felt they had to give their volunteers more attention than paid staff. As one project coordinator said:

“You are dependent on volunteers, you can't treat them as paid staff so you have to pamper them all the time and unfortunately they just leave.”

Referral processes

Older people accessed the different projects by referral from another organisation, answering an advertisement in the newspaper or on local radio, word-of-mouth or responding to a project co-ordinator's presentation. The responsibility for referrals was that of the project co-ordinator, although they had limited time to focus on this aspect of their role. There was agreement amongst the co-ordinators that they were in the best position to understand their target group and, therefore, they should be allowed enough time to develop and establish a referral network. They recognised that it was time consuming for stakeholders and organisations to familiarise themselves with the telephone support projects and to develop a trusting relationship with them. Project co-ordinators highlighted this as an important factor to be considered when deciding on the length of funding periods since the funding often came to an end before a relationship with local stakeholders had been established or alternatively, funding was withdrawn just as a referral network was being developed. It was important to factor in sufficient time to establish formal stakeholder relationships when deciding on the amount of funding to be allocated to a project and the term of the funding. As one project co-ordinator pointed out,

“Nobody has seen it (telephone befriending service) before and anything new...takes a year for the people to get used to the name of it and trust in them”

Project co-ordinators suggested that the telephone support service should be administered in partnership with existing organisations that have specific procedures

in place for referrals, for example, social services. In addition, those professionals who were in regular contact with older people, for example, General Practitioners, nurses, social workers, care organisations, etc. should be targeted as part of an awareness raising exercise. For example, the co-ordinators suggested contacting local medical practices and care organisations to inform them of the services and the benefits they could offer their older populations.

“The biggest problem I think is that it’s (the telephone befriending service) not inter-linked with any other service. That’s why nobody feels obliged to refer anyone. I think a project of this sort should be linked so that you would get regular referrals”

In summary, the co-ordinators of befriending services in this study highlighted important changes that need to occur in the way services are organised, in particular in relation to operational structure, promotion and publicity, recruitment of volunteers and referral processes. Whilst recognising the difficulties of providing a truly person-centred service, they expressed frustration at the lack of trust between agencies and the problems of increasing awareness of the existence of the services.

Conclusion

The aim of this paper was to explore the organisational issues that project co-ordinators face in administering a telephone support service for older people. Our interviews with older people who received this service showed that it provided the means for socially isolated older people to become more confident and independent and develop a sense of self-respect, potentially leading to increased participation and meaningful relationships (Cattan *et al.*, 2011). However, the evidence from this study also indicates that there were restricting factors which hampered the day-to-day operation of the telephone support services, leading to a service that was unable to meet older people’s needs fully.

The main message from this study was that the services need to be flexible in order to meet the needs of older people. Projects may be limited in what services they are able to offer either as a result of restrictions placed by funding bodies or because of a lack of willingness to change within the services themselves. Importantly, our findings showed that participants wanted choice (Cattan *et al.*, 2011) and the project co-ordinators wanted the autonomy to be able to respond to participants’ choices. Government policy documents in the UK, such as ‘Our Health, Our Care, Our Say: A New Direction for Community Services’ (Department of Health, 2006), ‘Putting People First’ (HM Government, 2007) and the ‘Carers’ Strategy’ (Department of Health, 2008) emphasise the integration and personalisation of health and social care services. The emphasis is on statutory services listening and responding to people’s needs. The findings from our study suggest that likewise, telephone support services need to be adaptable and have the flexibility to be able to respond to their particular client base and, in doing so, satisfy older people’s needs. If project co-ordinators are willing, as all of them were in this study, they need to be allowed more independence to enable them to respond and meet older people’s changing needs over time. A related issue is that of finance and the freedom to decide how to best use money allocated to individual projects. Project co-ordinators wanted more control in respect of finances in order to manage service delivery more efficiently and improve outcomes for older people. Indeed, a bottom-up approach that allows older people and project co-ordinators to decide how to manage services is recognised as

delivering the best outcomes, as opposed to a government-mandated, top-down approach (Rummery, 2009). This would meet the expectations of the personalisation agenda, but would also require a certain amount of trust between the funder and service provider with regards to how the money is spent.

There was a strong agreement that clear referral pathways, linking voluntary and statutory bodies, improved the chances for isolated older people to access telephone support services. Although some older people contacted the services directly, it is possible that these were the 'active lonely' (Cattan *et al.*, 2003). Therefore, 'other' routes are required, which are accessible to those most in need of a telephone support service. This ties in with 'Our Health, Our Care, Our Say: A New Direction for Community Services' (Department of Health, 2006), which set out to improve access to community services and support people with long term needs. Improved access depends on statutory bodies' awareness of voluntary services in the first place, which increases through specific awareness raising exercises and is dependent on good and trusting communication between sectors and service longevity (Rummery, 2009). The project co-ordinators emphasised that the continued operation of the telephone support programme would result in the service increasing its profile and the number of referrals, but this could only happen if long term funding were available.

Long term funding depends on long term thinking, rather than the 'projectism' of current health agendas and the process of supporting short term projects (Reeve and Peerbhoy, 2007). Long term thinking requires a change in attitudes, where local users and service providers are involved in decision-making and have a say in how services are delivered. The telephone support services existed on a year-by-year basis and were dependent on short term funding being made available from Age UK. For the project co-ordinators this was significant, in terms of their inability to influence service delivery and as far as sustainability of the service was concerned. Project co-ordinators clearly wanted the telephone support service to continue for the benefit of the older people, but they could not envisage this happening unless the programme was mainstreamed and embedded in organisational practice. Likewise, South *et al* (2009) emphasise that only in an environment of long term funding, which involves service providers and service users in planning and delivery will services become more sustainable.

The current climate of short term funding represents a major barrier for changing the way in which services such as telephone support projects are managed and delivered. An additional barrier is the rigidity of organisational structures within large agencies where national priorities override local priorities. This can impact on the ability of project co-ordinators to make decisions that are in the best interests of, and meet the needs of, the local older people they represent. Furthermore, the present economic climate has had a negative impact on people's willingness to make changes and invest in programmes such as the telephone support service.

This study confirms that those responsible for managing and delivering telephone support services, as well as service users, are instrumental in decision-making and planning processes. Project co-ordinators bridge the gap between organisational bureaucracy and communities and, therefore, need to be empowered through supportive systems to maximise their way of working for the benefit of the older

people they serve. At a time when organisations are being streamlined in an effort to increase efficiency and effectiveness, there is a need for a wider cultural change in the way supportive programmes are viewed and funded. Only through appropriately developed and responsive services for older people will long term gains be made in respect of their health and wellbeing.

Implications for practice

Funding bodies need to listen and respond to the requirements of project co-ordinators and older people.

Project co-ordinators and older people should be given greater control in respect of decision-making and service delivery.

Trust between agencies is an essential factor to ensure user responsive services.

Long term funding that involves project co-ordinators and older people in planning and delivery is required if telephone befriending services are to become more sustainable.

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